Division of Health Care Facilities

PRINTED: 10/13/2015
FORM APPROVED

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TN1401 | A. BUILDING: 01 - MAIN BUILDING 01<br>B. WING | 09/28/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CELINA HEALTH AND REHABILITATION CENTI | 120 PITCOCK LANE<br>CELINA, TN 38551 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 831 | 1200-8-6-.08 (1) Building Standards<br><br>(1) A nursing home shall construct, arrange, and maintain the condition of the physical plant and the overall nursing home environment in such a manner that the safety and well-being of the residents are assured.<br><br>This Rule is not met as evidenced by:<br>Based on observations, the facility failed to maintain the overall environment.<br><br>The finding included:<br><br>Observation on 9/28/2015 at 10:20 AM, revealed a broken roof joist between firewall 2 and firewall 3 in attic.<br><br>This finding was verified by maintenance director and acknowledged by administrator during exit conference on 9/28/15. | N 831 | N831<br>1. The broken roof joist was repaired by the Director of Maintenance on 10/9/15.<br>2. The remaining roof joists were inspected on 10/9/15 by the Director of Maintenance to ensure that there are no other broken joists. No other roof joists were found to be affected.<br>3. The maintenance department was in serviced on 10/23/15 regarding the maintenance of the roof joists by the Administrator.<br>4. The maintenance director will examine the roof joists weekly for four weeks and then monthly for two months or until 100% compliance is achieved and thereafter to according to the facilities preventative maintenance plan. All results will be reported monthly x3 months by the Maintenance Director to the Quality Assurance Performance Improvement committee comprised of the Medical Director, | Completion Date<br><br>10/23/15 |

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paula Moore
TITLE: Administrator
(X6) DATE: 10/23/15

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Division of Health Care Facilities

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Paul Moore | Administrator | 10/23/15 |